Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

January 4, 2017

Ms. Elizabeth Rixon, Administrator
Pillsbury Manor - South
20 Harbor View Road
South Burlington, VT 05403-7850

Dear Ms. Rixon:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on November 8, 2016. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0149	A. BUILDING _____ B. WING _____	C 11/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILLSBURY MANOR - SOUTH	20 HARBOR VIEW ROAD SOUTH BURLINGTON, VT 05403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site investigation was completed on 11/8/16 by the Vermont Division of Licensing and Protection. The following regulatory violations were identified.	R100	By submitting this plan of correction Pillsbury Senior Communities denies any liability to any third party for any acts or omissions of itself, its principals, employees or agents, and denies that it violated any state rule or regulation, or violated any standard of care.	
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the home failed to provide the necessary care to meet the resident's nursing, personal and medical needs for 1 resident in the targeted sample. (Resident #1) Findings include: Subsequent to the facility's mandatory report of a resident death and complaints (2) related to resident quality of care and safety, a regulatory investigation found that an unsafe resident environment and lack of resident reassessment after a decline in medical condition, contributed to the accidental death of Resident #1. The resident became entrapped between his/her bed mattresses and a half side rail attached to the bed frame. The resident had an electric 'hospital type' bed in their room, originally ordered to help facilitate a decline in mobility. Per observation of the bed on 11/7/16, the bed was found to have 2	R126	R126 All residents personal, psychosocial, nursing and medical care needs will be met by the following; All residents requiring assistive devices added to beds will have bed and assistive devices assessed for safety by RN by the following protocols; A bed policy has been created stating any bed used in facility that requires any assistive device will be assessed and measured for safety and appropriateness for the resident. The community has the ultimate responsibility of approving any assistive device. Any bed will only allow one overlay. Scheduled in-service and retraining of staff for 1/13/2017. 12/23/16.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth McIlroy
TITLE: LPN Administrator
(X6) DATE: Jan 4, 2017

R126 - R266 POCs accepted 1/4/17 MBellonRN/pmc

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R126	Continued From page 1	R126		

mattress overlays placed on top of the original mattress (for a total of 3 mattresses). The resident was found sitting on the floor in front of the middle area of the bed on the night shift in early November, 2016. The resident's head was stuck face down between the mattresses and the side rail, per review of the written statement of the care giver who found the resident at approximately 0150 on 11/3/16. The caregiver called the charge nurse to the room. The RN (registered nurse) sent the caregiver to bring another caregiver to the room. Per telephone interview on 11/8/16, the RN charge nurse stated that the resident had a faint pulse when s/he arrived in the room and died shortly thereafter.

Per interview with the ADM, the resident was admitted to Hospice care during July, 2016 for end stage disease. When the surveyor and the ADM removed the top sheet from the bed, we observed that the bed had 2 overlays on top of the original mattress, the air mattress and a high density type foam overlay. (The ADM stated that Hospice provided the air mattress overlay that was observed on the bed on 11/7/16) The height of the 2 overlays was measured and totaled 6 inches in thickness (3.5 inches and 2.5 inches). The gap between the 2 overlays and the side rail was measured at 5 inches wide. If the resident were lying near the edge of the bed, or sitting near the edge of the bed, this would further widen the gap, posing a risk of entrapment. (It was noted that the regular mattress gap between the mattress and the side rail was much smaller, measuring at 3 inches; thus the overlays presented the entrapment hazard.)

It is unknown how the resident arrived in the position of having their face stuck between the bed overlays and the side rail, because there was

Administrator and Residential Care Director responsible for monitoring and compliance.

Administrator is working with fellow administrator to develop a side rail/safe bed assessment that will be used with every bed that requires an assistive device. This assessment will be completed upon receiving MD order and at least quarterly or with change of condition.
Assessment and policy to be ready 2/1/2017.

12/23/16.

Have secured a physical therapist to come and retrain licensed staff how to assess safety of bed.
In-service scheduled for 1/13/2017.

Administrator and Residential Care Director to be responsible for monitoring and compliance.

Community will maintain adequate staffing ratio on all shifts to meet care needs of all residents. Ongoing. 11/3/16.

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R126	Continued From page 2	R126		

no witness. Nonetheless, being entrapped in this space caused a series of events that ended with the resident's death shortly after being found. The injuries seen by the pathologist's examination were consistent with positional asphyxiation due to bed rail, not as a result of a fall.

Regarding resident assessment, facility nurses failed to do a re-assessment of the appropriateness and safety of having side rails on the resident's bed. During the previous 2 months, the resident did experience 2 falls from bed without apparent injury. The resident's care plan stated the resident required the use of a Hoyer mechanical lift with 2 staff assist for transfers to and from the bed. This was also confirmed during interviews with the resident's daughter and the ADM on 11/7/16 and 11/8/16. The ADM stated that the electric bed was originally rented because the resident's personal bed was too high for the resident to safely transfer; the electric bed could be raised and lowered as needed. At the time the bed was rented , the daughter also rented a foam overlay for the bed which the rental company stated would increase her mother's comfort. The mother was admitted to Hospice Services in July and the ADM stated that Hospice staff brought in the air mattress overlay, which was placed on top of the regular mattress and the foam overlay. It was not known if facility nurses and Hospice nurses were aware that there were 2 overlays on the bed at the same time. The overlays are narrower than the regular mattress and easily slide from side to side, creating the gap between the side rails and the mattresses.

On the night of the resident's death, the facility had insufficient trained staff on duty to assure a safe environment and meet all resident's needs. There was 1 experienced caregiver (CG), 1

Administrator and Residential Care Director responsible for monitoring and compliance.

Community has mandated between shift room to room safety checks (caregiver to caregiver) to be documented in a log. 12/9/2016.

Residential Care Director responsible For monitoring and compliance.

Pillsbury notes that resident was seen and repositioned at 10:50pm.

Community has invested in HIPPA compliant two way radio syster improve staff communication. 12/30/2016.

Reviewed and updated night shift duties Checklist.
Night staff to sign that each round is completed. 11/08/2016.
Administrator and Residential Care Director responsible for monitoring and compliance.

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R126	Continued From page 3	R126		

orienting CG, plus a RN on duty. The usual night shift staffing included 2 CG and a nurse or Med Tech/CG charge. The RN, who worked at the facility per diem, stated that s/he did not delegate assignments to the CG and the orientee that night. During a phone interview on 11/8/16, the RN stated that she had not confirmed with the CGs that they should remain together and do bed checks together since one of them was orienting. Per staff interview, bed checks are to be done at 11 PM, 1 AM, 3 AM and 5 AM on the night shift. The resident was not checked at 11 PM, per routine process per staff interview. The orientee had been sent alone to check on a resident on another wing by the experienced CG. Per the ADM, this was not acceptable and not part of the orientation process. The RN on duty failed to provide the appropriate supervision to the CG on duty. The orienting CG, working alone, found the resident at 0150 on 11/3/16.

In summary, the facility failed to assure a safe environment in all areas for all residents, failed to re-assess a resident who had a decline in health status and update the care plan as needed, and failed to ensure that there were sufficient numbers of trained staff on duty on the night shift. The facility also failed to assure that nurses/designated charge staff fulfilled their duty to supervise and assign resident care to assure that each resident's physical and safety needs were met in a timely manner.

Refer also to all following tags.

A risk management committee has been created and will in addition meet monthly to review every incident. Will assess and problem solve all incidents, with focus on prevention and decreasing repeated incidents. First committee meeting scheduled for 1/13/2017. One of the charges of this committee will include regularly scheduled safety rounds.

12/8/2016.

Residential Care Director responsible for monitoring and compliance.

New policy created and staff is being retrained on elements of a safety check. Explanation of a safety check added to orientation checklist and to care plan as well as service check off list. 1.4.2017

Administrator responsible for monitoring and compliance.

R136 SS=G V. RESIDENT CARE AND HOME SERVICES R136

5.7. Assessment

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R136	Continued From page 4 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the nurse failed to assure that 1 applicable resident in the targeted sample was re-assessed after a change in medical condition. (Resident #1). Findings include: Per interviews with facility nursing staff and the ADM, Resident #1, who had experienced a decline in overall health status and had been admitted to Hospice Services in July, was not re-assessed regarding the safety of having 2 half side rails remain on the bed. The resident was a Hoyer lift (mechanical lift) with 2 staff assist, and had severely restricted voluntary movements. The resident had experienced 2 recent falls from bed without injuries in September and October, 2016. During early November, the resident was found on the floor, sitting position with legs extended in front of h/her, and with the head caught between the mattresses and the half side rail. The resident was determined to be alive when the nurse entered the room after being notified of the fall by a caregiver. The resident died a short time later of "positional asphyxiation" and end stage disease per the post mortem examination. Refer also to R 126.	R136	R136 Community will assure all residents are assessed at any point in which there is a change in the resident's physical or mental condition by; Any mental or physical change of condition as well as any incident report generated will trigger the following response; If the resident has a change of condition, decline or improvement, an assessment form will be completed for review so that it can be determined if the resident is appropriately placed. The process will include immediate investigation of any change of condition or documented incident by nursing staff to review and updated plan of care, caregiver service plan and state assessment form and any other appropriate assessments. Every incident report will be reviewed, analyzed and signed off on by RN within 72 hours to assure timely reassessment. 12/20/16. Residential Care Director responsible for monitoring and compliance.	

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R145	Continued From page 5	R145		
R145 SS=G	V. RESIDENT CARE AND HOME SERVICES	R145		

5.9.c (2)

Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to assure that the care plan for 1 applicable resident in the sample was kept current and addressed all of the resident's needs. The facility also failed to assure that staff implemented the interventions for Safety Checks, as required. (Resident #1). Findings include:

Per record review and confirmed by interviews with the ADM, and nursing staff, Resident #1 had a decline in health status, loss of mobility function and had an electric 'hospital type' bed with 2 half side rails on the upper bed side. Per interview with the resident's daughter and the ADM, this bed was rented to help the resident with their declining mobility function, to enable easier transfer in and out of bed (March, 2016) During July, 2016, the resident was admitted to Hospice Services. Per review, the most recent care plan failed to include the side rails on the bed, which could be restrictive and constitute a safety hazard for this resident.
In addition, staff failed to follow the care plan for

R145
All resident care plans will address all resident needs; to be completed and reviewed by RN at least quarterly to assure compliance. All care plans were reviewed and updated on 12/2/2016 by RN and again on 1/1/17 by LPN.

Resident Care Director
will assign care plans to be reviewed and updated monthly or bi monthly using the following method of monthly progress notes;

Every month or two each resident needs a progress note written in their chart to reflect how the resident is doing. These notes will be assigned requiring initialing upon completion and need to be completed in a timely fashion.

Information needed should include the following:

Monthly vital signs & weight
Socialization with other residents, tablemates, friends and family-outings.
Participation in activities includes what they like to do even in their room.
Appetite and diet
ADL functioning and amount of assistance needed include bathing, grooming hygiene and dressing A.M & P.M.

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R145	Continued From page 6 the overnight shift of 11/2/16 - 11/3/16 by failing to conduct safety checks per instructions. Night staff interviewed on 11/8/16 stated that resident safety rounds are to be done at 11 PM, 1 AM, 3 AM and 5 AM on the night shift. Per interviews with staff on duty that night, and review of written statements, the 11 PM checks were not completed for Resident #1, who was found on the floor at 0150 on 11/3/16 and expired due to injuries and end stage disease a short time later. Refer also to R 126 and R 146	R145	Ambulating and Transfers use of assistive devices i.e. cane or walker. Behavioral issues and use of anti-anxiety, anti-depressants, anti-psychotics include effectiveness and any side effects. Bowel and bladder- If they are incontinent how managed, use of briefs, toileting schedules, etc. Make sure to include improvements as well as deterioration. Anything else that you feel is pertinent such as: doctor visits & outcomes. Review and update Care Plan and Problem list and update as needed change date and initial your review. Check Pain Management Flow sheet and document how it is going The monthly progress note is not considered completed until the care plan has been reviewed and updated so the RN can evaluate; and the previous 30 to 60 days progress notes are reviewed for timely, and accurate documentation (see R150) They will be checked on monthly and at random. 1/2/2017. Residential Care Director responsible for monitoring and compliance.	
R146 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the nurse failed to assure that staff were provided instruction and supervision regarding the health needs of the residents of the home for the night shift. The failure affected the care provision to one applicable residents in the sample. (Resident #1). Findings include: Per interviews with nursing staff and the ADM after Resident #1 died accidentally, interviews with 3 nurses or charge staff that work on the night shift revealed that not one of the 3 interviewed routinely provides instruction and supervision to all caregivers working on their shift. For the night of Resident #1's accidental death,	R146		

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R146	Continued From page 7 the RN stated that she was aware that they had 1 less staff on duty for the night and that the staff present included a caregiver (CG) and an orientee CG and h/her self. The nurse was employed as per diem status, and worked occasionally. The RN stated that she did not confirm any assignments for the CGs that night. S/he stated that CG told her that s/he would be on one wing and the orientee would be on the other; the RN confirmed that she was aware that the other CG was orienting and stated, 'I never thought s/he would have him/her doing rounds on their own'. The RN said that the staff were not knowledgeable, however, s/he did not go over the assignments for the shift to assure that all residents received the care they required from the CGs on duty. Refer also to R 126 and 145.	R146	R146 All direct care staff to receive instruction and education regarding all resident needs as evidenced by; Each resident has a Resident Service plan for daily caregiver assignments. Service plans are developed and attached directly from the care plan. Service plans are given to each caregiver daily on each shift with detailed information relating to the resident's needs. A charge person orientation now includes specific dialogue regarding responsibility of delegation of duties; including importance of charge person to charge person report and then charge person to team report to assure continuity of care to all residents. 12.2.2017 Retraining in-service scheduled for 1/26/17 Administrator responsible for monitoring and compliance.	
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the RN (registered Nurse) failed to accurately document all observed signs of injury after an accident resulting in serious injury to 1 applicable resident in the targeted sample.(Resident #1) Findings include: Per review of a progress note by the RN on duty for the overnight shift of 11/2/16 - 11/3/16,	R150	R150 Nursing staff to receive re-education and training on complete and accurate documentation. In-service scheduled 2/2017	

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R150	Continued From page 8 Resident #1 was found sitting on the floor with ...legs bent....stretched in front of her/him, back against the bed...head slightly to the left." The only observed injuries documented in the progress note included "scant fresh blood on ...chin and on the upper half rail, a few inches from ....the chin." Per telephone interview on 11/8/16 at 11:20 am, the RN stated that the "resident was sitting there, blood below the chin or below the nose, so event just happened...." When asked again what was seen, s/he stated there was a large triangular shaped bruise just below his/her chin; the nurse stated "that didn't make any sense to me". When the RN was asked what the caregiver stated to /him/her after s/he found the resident, the nurse stated that the caregiver said something about the face "was stuck". There was no evidence of any further RN review of the incident with the caregiver, despite an observed injury that "made no sense to him/her." There was no documentation in the record of the injury revealed by the nurse during the telephone interview. Refer also to R 126	R150	Administrator and Residential Care Director will assign monthly audits of documentation by charge nurse staff. Assigned staff will review assigned charts for appropriate, accurate, and timely documentation while doing assigned monthly progress notes and report any concerns to team mate and Residential Care Director. 1.2.2017 Residential Care Director responsible for monitoring and compliance. Review plan of disciplinary action to include; lack of RN to delegate duties lack of accurate documentation lack of adequate assessment regarding statement to surveyor Employee is not presently working in this community. 1/11/2017 Executive Director and Administrator responsible for monitoring and compliance.	
R178 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	R178	R178 Will maintain sufficient staffing ratio on all shifts to meet care needs of all residents. Ongoing. Administrator and Residential Care Director responsible and will cross cover and audit staffing. Will implement the use of staffing agencies when necessary.	

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R178	Continued From page 9	R178		

facility failed to assure that there were sufficient numbers of qualified staff on duty at all time to provide the necessary care to maintain a safe environment and assure prompt action in cases of injury or other emergencies for all residents of the home. (Resident # 1). Findings include:

Per interviews with staff and staff schedule review after the accidental death of Resident #1 on 11/3/16, it was revealed that the night shift had 1 CG and 1 orientee on duty with the RN that night. The usual staffing at night included 2 CGs and 1 charge nurse/designee. The census at the time was 64 residents. Staff on duty were not assigned specific duties by the RN and the lead CG decided that the orientee could go and do rounds on one wing of the home alone, and they would do the other wing. The CGs are supposed to do Safety Checks rounds at 11 PM, 1 AM, 3 AM and 5 AM. The 11 PM rounds were not done that night and the orientee reported that he found Resident #1 sitting on the floor in front of the bed, with their head stuck between the mattress and the side rail at 0150 Hr. The orientee had been sent to the other wing to answer a call bell by the CG. This was the 4th shift that the orientee had worked since the beginning of their employment at the facility. Per interview with the RN and the ADM, each confirmed that the orientee should have been working with an experienced CG for all care. Per review of the orientee written checklist, most of the areas requiring evidence of completion were not completed.
Refer also to R 126

R190 V RESIDENT CARE AND HOME SERVICES R190
SS=D

5.12.b.(4)

All staff will have completed their orientation checklist and be signed off on their duties before doing anything independently.

11/8/2016

Administrator responsible for monitoring and compliance.

Orientation checklist has been elaborated on in much greater detail. Pillsbury notes that the caregiver in this incident had more than 10 years' experience and had new employee orientation and 2 nights of one on one orientation prior to this night.

Ongoing quality assurance will be taking place through a new partnership with Relias learning which will enable Pillsbury to provide on demand training to our staff. This training will both be mandatory to make sure our staff are trained in key areas as well as voluntary for staff to continue their education in areas of their choosing. 2/2017

Resident Care Director has also revamped our in person mandatory training schedule to include but not limited to; (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. 11/8/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0149	A. BUILDING: _____ B. WING _____	C 11/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILLSBURY MANOR - SOUTH	20 HARBOR VIEW ROAD SOUTH BURLINGTON, VT 05403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R190	Continued From page 10 The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that RCH (Residential Care Home) required background checks were completed for all staff employed by the home. Findings include: Per review of a sample of staff for background check completion, 1 of 4 personnel records reviewed was missing evidence for the Vermont Criminal Record check's review. The ADM confirmed that s/he was not aware of the lack of evidence of the VT Criminal Record check for this staff person.	R190	R190 All background checks will be done per regulations. One statewide criminal background check was not available at time of investigation. State website was unable to provide document due to technical difficulty. All background checks are done, clear and in compliance. 11/9/2016 Human Resources responsible for monitoring and compliance.	
R200 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop written policies/procedures to govern all services provided by the home regarding resident care for 1 resident in the targeted sample. (Resident #1). Findings include:	R200	R200 Resident Emergency Policy created. Bed Policy created. Safety Check Policy created. 1/2/2017 Administrator and Executive Director responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R200	Continued From page 11 Per staff interviews and record review, the facility did not have a written policy/procedure to describe "Safety Checks" for residents. Resident #1's care plan stated that the resident was to have Safety Checks, but there was no written procedure to direct staff in this type of care. Per interview with the ADM after Resident #1's sudden accident and death, when asked what would be expected after finding a resident with significant change of health status after being found on the floor, the ADM said she would expect the nurse to call 911/Rescue. This did not happen after Resident was found with weak VS (vital signs) after being found on the floor in their room on 11/3/16. The ADM stated that despite the fact that the resident was receiving Hospice Services, she was not imminently dying and would expect emergency services to be called in the case of any resident accident with potentially unknown injuries. The ADM confirmed that the facility had no written policy/procedure to direct staff in case of resident emergencies.	R200		
R266 SS=G	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure that the environment for all resident's of the home remained safe at all times. This practice affected 1 applicable resident in the	R266	R266 Community will provide and maintain a safe, functional, sanitary, homelike and comfortable environment by; Community will follow all newly created policies and begin re educating staff immediately. Scheduled meeting 1.26.17	

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R266	Continued From page 12 sample. (Resident #1) Findings include: Per interviews with staff and family members after the accidental death of Resident #1, nursing staff failed to recognize and assess the safety of half bed rails with 2 overlays on the regular mattress in Resident #1's bed. The ADM stated that the family had rented the 'hospital bed' in March, 2016 to help the resident with portioning and mobility because the resident's own bed was too high from the floor. The resident's daughter stated during interview that the rental company suggest a foam overlay be included with the regular mattress to offer increased comfort for the resident. The bed arrived with the foam overlay. During July, 2016 the resident was admitted to Hospice Services and the ADM stated that the Hospice nurse provided an air mattress overlay for the bed. This was placed on the bed, in addition to the foam overlay. Together, these 2 mattresses could easily slide from side to side, creating gaps between the mattresses and the side rails. On 11/3/16, the resident was found entrapped with their head between the mattresses and the side rails and their body resting on the floor in from of the bed, legs outstretched. The care giver who found the resident reported that the resident's head was 'stuck between h/his bed and the grab bar'. Staff's failure to assess the safety of the bed with the two overlays on the regular mattress resulted in a safety hazard and a tragic outcome for the resident. The death was ruled "positional asphyxiation" by a pathologist. Refer also to R 126	R266	To include training and education on all new pieces of resident equipment being first assessed by RN for safety and appropriateness and then RN to educate appropriate staff. 1.2.2017 Residential Care Director responsible for monitoring and compliance.	

SAFETY CHECKS

A safety check is direct visual contact with a resident at a designated frequency to reasonably determine if or ensure that the resident, their situation or their environment is safe.

If the staff member finds the resident in anyway compromised or unsafe, they are to immediately report to the charge person, and assist per delegation of the charge person.

01/02/2017 emr

BED POLICY

Any bed that is in Pillsbury Senior Communities that requires any alteration in anyway; or if a hospital bed is ordered, will be assessed for safety and appropriateness for the resident. It must be ordered by a physician (including the need for half rails if applicable) and may only have one additional overlay for safety. Each bed must allow resident to exit safely. An example of this is a hospital bed with a side rail for a resident on hospice.

To properly assess the safety risk of side rails the staff must measure the danger areas for entrapment (see FDA measurement recommendations); areas of critical concern include the mattress, including any type of overlay on the bed and the side rails.

Safe bed checks will be done upon introduction of the device or bed to the community and quarterly thereafter or with change of resident condition to assure safety.

1.2.2017 emr

Resident Emergency Policy

In cases where a resident suffers a sudden and unexpected deterioration of physical condition or vital signs, A charge person will call emergency services immediately, giving due consideration to end-of-life directives or hospice care directives.
If emergency services are not to be called due to such considerations, the charge person will contact the nurse administrator or executive director.

emr 1/2/2017